HOSPITAL STAKEHOLDER ENGAGEMENT MEETING

Friday, November 1, 2019
9:00 AM - 12:30 PM

Location: The Department of Health Care Policy & Financing, 303 East 17th Avenue, Denver, CO 80203. 7th Floor Rooms B&C.

Conference Line: 1-877-820-7831 Passcode: 294442#

Topic Suggestions, due by close of business one week prior to the meeting. Send suggestions to Elizabeth Quaife at elizabeth.quaife@state.co.us

Welcome & Introductions

- **Thank you for participating today!**
- We are counting on your participation to make these meetings successful

GROUND RULES FOR WEBINAR

- **WE WILL BE RECORDING THIS WEBINAR.**
- **ALL LINES ARE MUTED. PRESS *6 IF YOU WISH TO UNMUTE. PARTICIPANTS CAN ALSO UTILIZE THE WEBINAR CHAT WINDOW**
- If background noise begins to interrupt the meeting, all lines will be muted.
- Please speak clearly when asking a question and give your name and hospital

Thank you for your cooperation

AGENDA

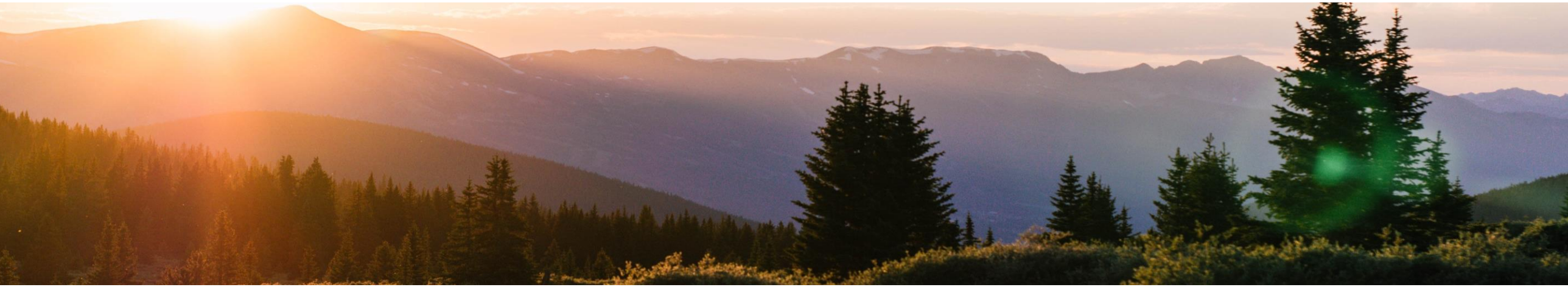
HOSPITAL ENGAGEMENT MEETING TOPICS 11/1/2019 9:00am - 12:30pm
Plans of Safe Discharge
NPI Law
SCR Updates
Inpatient Engagement Meeting Topics Received
Inpatient Base Rates Fiscal Year 2019-20 CMS Approved
Separating Mom and Baby Claims
Hospital Peer Groups/Definitions/Base Rate Reform (IP/OP)
Outpatient Engagement Meeting Topics Received
Zulresso
3M Module Update
DME & Transportation Clarification
EAPG Drug Carveout *ADDED*
JW Modifier
CDPHE Regulatory Review *ADDED*
HTP and Rural Support Fund *ADDED*
Staffing Updates *ADDED*

Dates and Times for Future Hospital Stakeholder Engagement Meetings in 2019

Dates of Meetings	Meeting Time
January 10, 2020	1:00pm-4:00pm
March 6, 2020	9:00am-12:00pm
May 1, 2020	9:00am-12:00pm
July 10, 2020	1:00pm-4:00pm
September 11, 2020	1:00pm-4:00pm
November 6, 2019	9:00am-12:00pm

The agenda for upcoming meetings will be available on our external website on a Monday the week of the meeting. https://www.colorado.gov/pacific/hcpf/hospital-engagement-meetings

Please note the offset dates and times to work around holidays AND Medical Services Board



PLANS OF SAFE DISCHARGE

Presented by:

Anne M. Hall, MD

Assit. Prof of Pediatrics, Section of Neonatology, University of CO

Children's Hospital Colorado

Matt Holtman, MSW, LCSW

CAPTA Administrator, Division of Child Welfare

COLORADO
Office of Children, Youth & Families
Division of Child Welfare

SAFE DISCHARGE OF THE SUBSTANCE EXPOSED NEWBORN

- Infants exposed to substances in utero are at high risk
  - increased risk attachment disorders
  - neurodevelopmental and behavioral issues
  - safety concerns due to drug seeking behaviors

- Discharge of any infant exposed to substances, prescribed or illicit, should include careful planning and involvement of a multidisciplinary team.

SAFE DISCHARGE OF THE SUBSTANCE EXPOSED NEWBORN

Timing for discharge

- Physiologic maturity of the infant
- Resolution of medical issues
- Appropriate discharge planning and follow-up have been completed
- Parent/Caregivers have received all necessary education and training

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

- Key federal legislation addressing child abuse and neglect
- Recent amendment 2016 – Comprehensive Addiction and Recovery Act

SAFE DISCHARGE OF THE SUBSTANCE EXPOSED NEWBORN

- Development of Discharge Guidelines to meet CAPTA goals
- Adapted from the 2008 AAP Guidelines from the Committee on Fetus and Newborn regarding the Hospital Discharge of the High-Risk Neonate
- SEN-specific language for hospital Discharge Summary

DISCHARGE PLANNING

Development of comprehensive home-care plan should be completed prior to discharge by a multidisciplinary group

DISCHARGE PLANNING…

- Components of a home-care plan should include:
  - Identification of in-home care givers
  - Formulation of a plan for nutritional and medical care
  - Development of a list of required supplies if applicable
  - Identification of primary care physician (PCP for infants and caregivers)

DISCHARGE PLANNING…

- …Components of a home-care plan should include:
  - Identification of community resources/treatment programs for caregivers
  - Assessment of the home environment
  - Development of emergency care and transport plan
  - Assessment of financial resources

ARRANGEMENTS FOR FOLLOW-UP

- Verbal communication with the PCP prior to discharge
- Neurodevelopmental follow-up or Early Intervention Referral
- Follow-up for the caregiver should be identified and arranged prior to discharge
  - Follow-up with PCP
  - Follow-up with Social worker/case worker after discharge
  - Follow-up with treatment program and/or counselor if applicable
  - Visiting home nurse if available

PARENT/CAREGIVER EDUCATION

- Parents/caregiver must be present during hospitalization and display competency in cares of the infant prior to discharge.
  - When possible at least 2 caregivers should be identified
- Parents/caregiver must exhibit readiness to assume full responsibility for the infant's care after discharge.
  - Development of an individualized teaching plan
  - Consider creating checklist or outline of tasks

BENEFITS TO THE FAMILY

- The Plan of Safe Care information may be used to assist with screening decisions.
- It may help with locating safe natural supports for the family and prevent unnecessary removals.
- It may provide information of potential caregivers if placement is required.

BENEFITS TO THE FAMILY

- This is a portable plan which ensures all systems are speaking the same language. Discharging hospital, mother and baby's PCP, child welfare, treatment facility or provider all sharing one plan.
- Helps to ensure a focused intervention and accountability for everyone.

NEXT STEPS

- Disseminate statewide to hospitals caring for SEN
- Disseminate statewide to child welfare departments

CONTACT INFORMATION

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COLORADO
Office of Children, Youth & Families
Division of Child Welfare

Colorado NPI Law

Scott Lindblom

Kaitlyn Skehan

Revalidation & Colorado NPI Law

Revalidation

- At least every 5 years
- Starting April 2020
- A six (6) month notice via email in advance of their enrollment deadline
- Action: **Update email addresses in provider enrollment profiles to receive these notices**

Colorado NPI Law

- Organization Health Care Providers (not individuals) must obtain and use unique and separate National Provider Identifiers (NPIs) for each **Service Location** and **Provider Type**
  - Impacts both Enrollment & Claims
- New Providers & Off-Campus Locations: Jan 2020
- Current Providers: Jan 2021
- Rule Effective Date: 11/30/19

For questions regarding the Colorado NPI Law, email HCPF_ColoradoNPIlaw@state.co.us or visit https://www.colorado.gov/pacific/hcpf/colorado-npi-law

System Change Request (SCR) Updates

- Part B Only (43373) – Completed. In production on October 2, 2019.

- LTAC and Rehab Per Diem (44201) – In process of system implementation by DXC. SPA and Rule approved.

- IPP-LARC (42654) – In process; pending SPA and Rule approval

- Observation (43991) – Beginning stages; looking at solutions implemented in other DXC states

Inpatient Topics/Questions Submitted

Topic	Brief Description	Status
Retro PAR	Client is admitted to hospital and during the stay is determined to be Medicaid eligible. Retroactive Medicaid completed after discharge. Is a retro PAR (for qualifying services) still required?	With PAR Team

Hospital Rates Updates

Rates Effective 7/1/2019

- All reprocessing has been completed for the FY2019-20 rate loads.

- The 10/1/2019 ICD-10 Code Updates have been completed and did not require any claims reprocessing.

- If you find claims that have not been priced correctly, please send ICNs to Diana Lambe at diana.lambe@state.co.us.

FY2020-2021

- Rate build for FY2020-21 starts now.

Separating Baby from Mother's Claim

How do we estimate the DRG-SOIs for 16,811 missing well-baby claims?

CLAIM TYPE	CLAIM COUNT	OLD PMT	EST NEW PMT	DIFFERENCE
Delivery DRGs	22,524	$$$$$	$$$$$	↓
Neonate DRGs	5,713	$$$$$	$$$$$	↔
Estimated Missing Well-Baby Claims using 640-1 and FY19 Rates	16,811	$0	$$$$$	↑
TOTAL	**45,048**	**$$$$$**	**$$$$$**	**$0**

Separating Baby from Mother's Claim

- About 8,700 DRGs have been identified for babies that did not stay past their mother's discharge.

- 88% (~7,700) are for DRG 640, the rest are spread across 25 neonate DRGs.

- This information comes from three hospitals and accounts for 52% of the ~16,800 "claims" where there is no data.

- A big **"Thank You!!"** to Denver Health, SCL and UC Health for providing the missing data.

- We are re-pulling claims data to match CY2018 data and will provide more information during the March 2020 meeting.

Separating Baby from Mother's Claim

BABY'S WHO LEFT HOSPITAL WITH MOM	
581	NEONATE, TRANSFERRED < 5 DAYS OLD, BORN HERE
588	NEONATE BWT <1500G W MAJOR PROCEDURE
589	NEONATE BWT <500G OR GA <24 WEEKS
591	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE
593	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE
602	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
603	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION
607	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
608	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION
609	NEONATE BWT 1500-2499G W MAJOR PROCEDURE
611	NEONATE BIRTHWT 1500-1999G W MAJOR ANOMALY
612	NEONATE BWT 1500-1999G W RESP DIST SYND/OTH MAJ RESP COND
613	NEONATE BIRTHWT 1500-1999G W CONGENITAL/PERINATAL INFECTION
614	NEONATE BWT 1500-1999G W OR W/O OTHER SIGNIFICANT CONDITION
621	NEONATE BWT 2000-2499G W MAJOR ANOMALY
622	NEONATE BWT 2000-2499G W RESP DIST SYND/OTH MAJ RESP COND
623	NEONATE BWT 2000-2499G W CONGENITAL/PERINATAL INFECTION
625	NEONATE BWT 2000-2499G W OTHER SIGNIFICANT CONDITION
626	NEONATE BWT 2000-2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM
630	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE
631	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE
633	NEONATE BIRTHWT >2499G W MAJOR ANOMALY
634	NEONATE, BIRTHWT >2499G W RESP DIST SYND/OTH MAJ RESP COND
636	NEONATE BIRTHWT >2499G W CONGENITAL/PERINATAL INFECTION
639	NEONATE BIRTHWT >2499G W OTHER SIGNIFICANT CONDITION
640	NEONATE BIRTHWT >2499G, NORMAL NEWBORN OR NEONATE W OTHER PROBLEM

Base Rate Reform Development

Development of DRG Hospital Rates:

- Myers and Stauffer has established a system of computer programs that utilize a detailed line item approach using claims data and hospital cost reports to estimate the cost of individual claims.

- This allows inpatient DRG weight setting and hospital rate setting to possibly be based on either submitted hospital charges or costs.

- They also calculate not only total cost for any claim but also split the cost into operating and capital components.

Data Sources

- As-Submitted Cost Reports for 2018 FYE
- Medicaid Claims Data for CY 2018

Base Rate Reform Development

Process

- Claims Data Review and Editing *(if necessary)*
- Claim Level Costing
- Costing Analysis
- Calculation of Hospital CMIs
  - Utilizing Paid DRG listed on Claim & CO V33 APR-DRG Weight
- Computation of Hospital Cost per Discharge
  - All Costs Inflated to SFY 2021
  - Cost Per Discharge Includes Both Capital and Operating
- Determination of Budget Neutral Hospital Specific Rates
  - Modeling Rates
    - Hospital Specific
    - Statewide
    - Peer Group

Base Rate Reform Development

- Revenue codes are routed to cost centers.

Standard Revenue Code Crosswalk
Medicaid Costing for FY2020 Hospital Cost Reports
EXAMPLE

Revenue Code	Description	Primary Cost Center	Secondary Cost Center	Tertiary Cost Center	Fallback Rate
A	*B*	*C*	*D*	*E*	*F*
001-099	INVALID	NC			
100-109	All Inclusive Rate	NC			
110	Private Room & Board	Routine			
111	Private Room & Board: Medical/Surgical/Gyn	Routine			
112	Private Room & Board: OB	Routine			
170	Nursery	Nursery			Routine
171	Nursery: Newborn-Level I	Nursery			Routine
172	Nursery: Newborn-Level II	Neonatal ICU	Nursery		Routine
173	Nursery: Newborn-Level III	Neonatal ICU	ICU		Routine
230	Incremental Nursing Charge	Routine Ancillary	ICU CCR		Ancillary
231	Incremental Nursing Charge: Nursery	Neonatal Ancillary	Neonatal ICU CCR	Nursery CCR	Ancillary
232	Incremental Nursing Charge: OB	Routine Ancillary	ICU CCR		Ancillary
233	Incremental Nursing Charge: ICU	ICU CCR	Routine Ancillary		Ancillary
234	Incremental Nursing Charge: CCU	Coronary Care CCR	Routine Ancillary		Ancillary

Base Rate Reform Development

- Revenue Codes are distributed to cost report line numbers, combined with per diem and current days from claim data for a calculated cost.
- Cost Allocations are made to create an Allocated Per Diem/CCRs.

Facility Cost Report Crosswalk - Detail Report

Provider: EXAMPLE

Revenue Code	Cost Report Line #	Per Diem	Current Days *Claims Data*	Calculated Total Cost	Cost Allocation Percentage	Allocated Cost	Allocated Per Diem	Cost Center Description
A	*B*	*C*	*D*	*E = C * D*	*F*	*G = E * F*	*H = G / D*	*I*
111	30.00	$ 650.40	9,565	6,221,076	100.00%	6,221,076	650.40	ADULTS & PEDIATRICS
118	41.00	$ 824.80	93	76,706	100.00%	76,706	824.80	SUBPROVIDER - IRF
121	30.00	$ 650.40	611	397,394	100.00%	397,394	650.40	ADULTS & PEDIATRICS
123	30.00	$ 650.40	1	650	100.00%	650	650.40	ADULTS & PEDIATRICS
164	30.00	$ 650.40	3	1,951	100.00%	1,951	650.40	ADULTS & PEDIATRICS
180	NC	$ -	28	-	100.00%	-	-	Non Covered
200	31.00	$ 1,181.88	2,237	2,643,866	100.00%	2,643,866	1,181.88	INTENSIVE CARE UNIT
210	32.00	$ 1,819.90	160	291,184	100.00%	291,184	1,819.90	CORONARY CARE UNIT

Revenue Code	Cost Report Line #	CCR	Current Charges *Claims Data*	Calculated Total Cost	Allocation Percentage	Allocated Cost	Allocated CCR	Cost Center Description
A	*B*	*C*	*D*	*E = C * D*	*F*	*G = E * F*	*H = G / D*	*I*
270	71.00	0.197743	2,088,391	412,965	100.00%	412,965	0.197743	MEDICAL SUPPLIES CHARGED TO PATIENT
272	71.00	0.197743	7,063,827	1,396,822	100.00%	1,396,822	0.197743	MEDICAL SUPPLIES CHARGED TO PATIENT
274	72.00	0.211040	11,915	2,515	100.00%	2,515	0.211040	IMPL. DEV. CHARGED TO PATIENTS
275	72.00	0.211040	515,178	108,723	100.00%	108,723	0.211040	IMPL. DEV. CHARGED TO PATIENTS
278	72.00	0.211040	6,451,210	1,361,463	100.00%	1,361,463	0.211040	IMPL. DEV. CHARGED TO PATIENTS

Base Rate Reform Development

- Resulting Allocated Per Diems/Cost Factors are used to estimate Cost for Claims.

Individual Claim Costing Example

Hospital A

Line Number	Revcode	Cost Center Line	Cost Center Description	Paycode	Units	Charges	Cost Factor*	Cost
Routine Revenue Codes								
1	111	30.00	ADULTS & PEDIATRICS		20	14,320.00	650.40	13,008.00
2	121	30.00	ADULTS & PEDIATRICS		13	8,931.00	650.40	8,455.20
3	210	32.00	CORONARY CARE UNIT		1	1,922.80	1,819.90	1,819.90
							Routine Cost Total:	**23,283.10**
Ancillary Revenue Codes								
4	250	73.00	DRUGS CHARGED TO PATIENTS		305	8,419.00	0.144546	1,216.93
7	270	71.00	MEDICAL SUPPLIES CHARGED TO PATIENT		235	3,815.00	0.197743	754.39
8	272	71.00	MEDICAL SUPPLIES CHARGED TO PATIENT		106	5,842.00	0.197743	1,155.21
14	310	60.00	LABORATORY		1	834.00	0.040462	33.75
15	320	54.00	RADIOLOGY-DIAGNOSTIC		3	1,792.00	0.118638	212.60
16	324	54.00	RADIOLOGY-DIAGNOSTIC		4	2,456.00	0.118638	291.37
17	351	57.00	CT SCAN		1	4,802.00	0.014423	69.26
18	360	50.00	OPERATING ROOM		3	8,718.00	0.109353	953.34
24	450	91.00	EMERGENCY		2	2,490.00	0.089540	222.95
25	460	65.00	RESPIRATORY THERAPY		6	522.00	0.094964	49.57
26	636	73.00	DRUGS CHARGED TO PATIENTS		690	18,444.00	0.144546	2,666.01
27	710	51.00	RECOVERY ROOM		7	6,782.00	0.075853	514.44
28	730	69.00	ELECTROCARDIOLOGY		1	445.00	0.056869	25.31
29	921	54.00	RADIOLOGY-DIAGNOSTIC		1	2,763.00	0.118638	327.80
							Ancillary Total:	**15,003.05**
							Total Cost:	**38,286.15**

Notes:

Cost Factor for Revenue Codes 219 and below is routine Per Diem (D-1, Part II)

Cost Factor for Revenue Codes 220 and below is ancillary Cost-to-Charge (CCR) - (C, Part I)

Base Rate Reform Development

- This is just a high level overview we received from Meyers and Stauffer recently.

- If you are interested, we can have them attend the next meeting in January if you can make sure you bring the correct individuals who will have an interest in this work.

Hospital Peer Groups and Definitions

- Through various projects it has become obvious that the current peer group designations are not granular enough
- Therefore the Department is considering the following peer groups
  - Urban
  - Rural
  - Frontier
  - Resort

County Designations

- Frontier* = any county with less than 6 people per square mile (based on land area)

- Rural* = A non-metropolitan county with no cities over 50,000 residents

- Resort = meet the following two criteria
  - Having 30% or more of the workforce in two tourist related industries based on census data
    - Arts, entertainment, and recreation
    - Accommodation and food services
  - Containing at least one ski resort

* Based on Colorado Rural Health Center's report named "Snapshot of Rural Health in Colorado - 2019": https://coruralhealth.org/snapshot-of-rural-health

Peer Group Designations

- Resort = located in a resort county and the closest hospital to a ski resort
- Frontier = located in a frontier county
- Rural = located in a rural county or a CAH; not included in the resort or frontier designation
- Urban = located in an urban county and not CAH
- The Department welcomes all feedback on these proposed designations

Outpatient Topics/Questions Received

Inquiries were not received and none are currently pending.

Zulresso (brexanolone)

- New IV infusion drug for postpartum depression
- Two locations in the state approved to administer
- Infusion given over a period of 60 hours
- Rule change necessary for administration in outpatient setting

EAPG Module Update

- 3M Released v.2019.3.0 on 9/26/2019
  - Accommodation of 10/1/2019 HCPCS/CPT updates, new ICD-10 code set
  - Also accommodated ICD-10 code set updates for APR-DRGs
  - Installed in DXC system on 10/3/2019

- No mass adjustments required

EAPG Module Update

- 3M Releases new module 12/27/2019
  - Yearly CPT/HCPCS updates
  - Targeting January 2, 2020 implementation date
  - No changes in Colorado payment policies
- EAPG Version 3.10 will remain in effect

DME & Transportation Clarification

- Hospitals must enroll as a DME Supply / Transportation providers in order to receive reimbursement for these services.
- Unbundled DME and transportation services should not be billed on outpatient hospital claim, and instead on the CMS-1500
- Transportation: August 2017 Provider Bulletin
- DME benefit will have more information forthcoming

EAPG Drug Carveout Analysis

- Modeled EAPG pricing versus Fee Schedule Pricing (4/1/18 to (3/31/19)

Hospital	EAPG Base Rate	Total EAPG Payment	Total Repriced Payment (Fee Schedule)	Fiscal Impact
A	270.01	$1,585,361.67	$2,591,927.32	$1,006,565.65
B	234.39	$560,696.34	$890,109.62	$329,413.28
C	312.67	$350,977.45	$643,522.27	$292,544.82
D	270.01	$161,997.77	$131,815.26	($30,182.51)
E	409.67	$154,346.04	$28,877.79	($125,468.25)
F	270.01	$275,495.30	$27,964.25	($247,531.05)

- Sampling shows winners and losers in this model

- Dependencies on hospital EAPG rates, mixture of drugs provided

Modification to EAPG Drug Weights

- Research in claims data and 2017 Hospital 2552-2010 form Worksheet C cost report data

- Converting claim charges to costs shows a significant difference in the average cost per drug detail in various groups

- If one group with a higher than average drug cost is removed from the rest then the others necessarily have a lower average drug cost

JW Modifier

- Outpatient hospital provider claims billed with the JW modifier for discarded drugs have been overpaying since the effective date of EAPGs on October 31, 2016. Per program policy, Health First Colorado does not reimburse for any drug which is discarded or not administered to a Health First Colorado member other than for a Medicare Crossover claim. This issue was resolved on 10-2-19. Claims will be reprocessed and funds will be recouped. Providers will be notified by email before recoupment occurs.

- **Adjustment Schedule (based on paid date):**
- March 1, 2017-December 31, 2017: Week of November 4, 2019
- January 1, 2018-December 31, 2018: Week of November 11, 2019
- January 1, 2019-October 4, 2019: Week of November 18, 2019

JW Modifier Adjustment Volume

Volume of claims to be adjusted in interChange by claim paid date:

- 2017: 383
- 2018: 1,264
- 2019: 1,891

- Individual hospital statistics unavailable for presentation for PHI purposes

CDPHE Regulatory Review

In October 2019 CDPHE started the stakeholder process for the regulatory review of 6 CCR 1011-1, Chapter 4 – General Hospitals, Chapter 10 – Rehabilitation Hospitals, Chapter 18 – Psychiatric Hospitals, and Chapter 19 – Hospital Units. These chapters cover a wide range of topics that impact hospitals, both general and specialty.

Meetings are open to the public.

When: Thursday, Nov. 7, 2019 from 1:30 – 3:30 p.m.

Where: Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246
Building C, Conference room C1E
(visitors, please check in at the front desk in building A, doors near the flag pole)

Audio line: 1-669-900-6833, conference code: 990 049 166

Webinar: Zoom meeting (https://zoom.us/j/990049166)

The stakeholder meeting schedule, agendas, documents and detailed information regarding the rule revision process can be accessed at this link: https://drive.google.com/drive/folders/1yTm15HQ_6pOdnL_jn9Lj1mpUUB6r-5qV?usp=sharing.

Meeting documents, schedules and archived agendas are available on the department website: https://www.colorado.gov/pacific/cdphe/chapter-4-hospital-rule-revision-meeting.

To sign up to receive email communications regarding the hospital rules review go to: https://goo.gl/forms/eWns4V9OU0pXkSsp2.

If you have any questions prior to then, feel free to contact Anne Strawbridge at anne.strawbridge@state.co.us or Monica Billig at monica.billig@state.co.us.

HTP and Rural Support Fund

Nancy Dolson

Special Financing Division Director

Staffing Update

Juan Espejo has left the Department as of October 24, 2019. Please forward hospital related questions to Raine Henry

Questions, Comments, & Solutions

Thank You!

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